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Welcome!

This month's newsletter provides an overview of quality improvement and quality measurement, as well as giving a closer look at continuing evaluation. Every edition will include links to the latest CMS Blueprint, as well as a calendar of upcoming opportunities and events.

We hope you find this newsletter useful and we welcome any feedback or suggestions to make it even better.

Please send comments or suggestions for future newsletters to MMSSupport@battelle.org.

Quality Improvement and Quality Measurement

The vision of the CMS Quality Strategy is to optimize health outcomes by improving quality and transforming the health care system. CMS serves the public as a trusted partner with steadfast focus on improving outcomes, beneficiary/consumer experience of care, population health, and reducing health care costs through improvement. Among the areas of focus are:

- Leading *quality measurement* alignment, prioritization, and implementation and the development of new, innovative measures;
- Guiding *quality improvement* across the nation and fostering learning networks that generate results.

The close connection between quality measurement and quality improvement is also evident in the Merit-based Incentive Payment System (MIPS) in which participants earn performance-based payment adjustments based on evidence-based and practice-specific data in the categories of quality, improvement activities, advancing care information, and cost (data collection starting in 2018).

Contents

How exactly are quality measurement and quality improvement connected? The starting point is always the definition of quality from the National Academy of Medicine: *the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge*[1]. Both quality measurement and quality improvement should increase the likelihood of desired health outcomes, using different but mutually supporting mechanisms.

The mechanism of quality improvement is *standardization*. First, behavior is made *systematic* so that the same inputs result in the same outputs within the bounds of uncertainty (randomness). Second, behavior is *aligned* with evidence (e.g. guidelines and systematic reviews). The PDSA Cycle (Plan-Do-Study-Act) is a systematic series of steps to identify the patient, process or system characteristics associated with "non-standardized behavior." Through each repetition of the PDSA Cycle, behavior becomes more systematic and more aligned[2]. We

standardize behavior through both structure and process. Structure might include things like physical capital (EHR), leadership or culture. Process might include knowledge capital (standard operating procedures) or human capital (education and training).

The mechanisms of quality measurement are *selection* and *choice*[3]. A quality measure is a tool for making "good decisions" defined as decisions that make it more likely to experience a good result and less likely to experience an adverse result that was not foreseen or was not understood. Consumers use quality measures to select high performing clinicians, and low performing clinicians choose to allocate resources to become high performing. Process measures that are based on evidence and well specified, and outcome measures that are reliable, valid, and risk-adjusted support "good decisions."

How are quality measurement and quality improvement mutually supportive? *Benchmarking* of quality measures using comparison groups of peers with similar patients, process and system characteristics suggests "best practices" that may be implemented in quality improvement. Process quality measures associated with outcome measures

decompose behavior into non-discretionary and discretionary components. When outcome measures are in the early phases of maturity, the discretionary components may suggest *concepts* for future biomedical, clinical, or health services research that may contribute to the advancement of professional knowledge[4].

References
1. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C.: National Academy, 2001. Print.
2. Langley, Gerald J. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. 2nd ed. San Francisco: Jossey-Bass, 2009. Print.
3. Berwick DM, James B, Coye MJ, Connections between quality measurement and improvement, Med Care, 2003;41(1 Suppl):I30-I38.n. New York: Duxbury, 2004
4. Califf, Robert M., Eric D. Peterson, Raymond J. Gibbons, Arthur Garson, Ralph G. Brindis, George A. Beller, and Sidney C. Smith. "Integrating Quality into the Cycle of Therapeutic Development." Journal of the American College of Cardiology 40.11 (2002): 1895-901. Web.

Measures Management Up Close

Each month, we will bring you an introspective look at a measures management topic.

A Closer Look at Continuing Evaluation

In the August 2016 issue, we provided an overview of Measure Use, Continuing Evaluation and Maintenance. In this article, we provide a closer look at Continuing Evaluation. Evaluation answers the question, "is the measure adding value and does it meet the required criteria?"

To help CMS ensure the continued soundness of the measures, the measure developer must provide strong evidence that a measure currently in use continues to add value to quality reporting and incentive programs and that its construction continues to be sound *throughout* its lifecycle. To determine this, CMS considers the following:

- Measurement results provide meaningful information to consumers and healthcare providers.
- Measurement results drive significant improvements in healthcare quality and health outcomes.
- The measure specifications accurately and clearly target the aspects of the measure that are important to collection and reporting.
- Collection of the data does not create an undue burden on those collecting it.
- The calculation methods provide a clear and accurate representation of variation in quality or efficiency of care or health outcomes.
- The measure is unique or "best in class" when compared to competing measures.

Some measures, such as Patient-Reported Outcome-Based performance measures, have additional criteria to meet. The overarching principle is that these measures should put the patient first. Patient-Reported Outcome-Based measures must be:

- Psychometrically sound—In addition to the usual validity and reliability criteria, cultural and language considerations, and burden to patients of responding should be considered.
- Person-centered—These measures should reflect collaboration and shared decision making with patients. Patients become more engaged when they can give feedback on outcomes important to them.
- Meaningful—These measures should capture impact on health-related quality of life, symptom burden, experience with care, and achievement of personal goals.
- Amenable to change—The outcomes of interest have to be responsive to specific healthcare services or intervention.
- Implementable—Data collection directly from patients involves challenges of burden to patients, health literacy of patients, cultural competence of providers, and adaptation to computer-based platforms. Evaluation should address how to manage these challenges.

Measure evaluation occurs throughout the lifecycle, from information gathering in the conceptualization phase to maintenance. To assist the developer and reviewers in this process, there is a Measure Evaluation Report available in the Blueprint for the CMS Measures Management System that lists the criteria it must meet - such as its scientific acceptability (the extent to which the measure produces reliable and valid results about the intended area of measurement) and its usability (how easy it is to use).

Measures must also be continuously reevaluated during maintenance, with reports submitted at specified periods. The comprehensive reevaluation must be completed every three years while the ad hoc reviews are conducted as needed. Measure updates are done to determine if there are opportunities for harmonization and to review the specifications. Though there may be differing evaluation details for the specific reevaluations, the general principles are the same. CMS uses evaluation results to help determine whether to adopt, retire, retain, revise, suspend or remove a measure.

Updated CMS Measures Inventory Now Posted

The CMS Measures Inventory and the Measure under Development (MUD) list have been updated and publicly posted on the CMS website (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/CMS-Measures-Inventory.html) on February 17th. The Inventory includes 31 programs, 2,064 unique measures, and is accompanied by the CMS Measures Inventory User Guide. The MUD List contains 29 programs and 522 unique measures. The next public posting will be in July 2017. For any questions regarding the Inventory or the MUD List, please contact MMSSupport@battelle.org.

CMS Measure Development Plan TEP & Environmental Scan and Gap Analysis Report

CMS recently posted the following two documents, the **Measure Development Plan (MDP) Technical Expert Panel (TEP) Nov 17th Meeting Summary** and the **CMS MDP Environmental Scan and Gap Analysis report** at the following CMS webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html (Follow the link and scroll down to section heading, "*Where can I find more information about the CMS MDP*").

Both documents focus on the initial set of priorities and specialty gap areas identified in the MDP, we anticipate identifying additional specialty and subspecialty priorities through ongoing environmental scans and gap analyses. Posting these documents underscores our commitment to transparency and knowledge sharing with stakeholders and

contributes to our larger efforts to gather expert input, evaluate the landscape of quality measures, reduce clinician burden, and fulfill our vision of a person-centered, value-based measure portfolio to support the Quality Payment Program.

JIRA Updates for 2017

To get access to the JIRA MUC 2017 site: First, users must have an ONC JIRA account in place. Then, send an email to MMSSupport@battelle.org. The JIRA MUC 2017 User Guide has been posted on the Pre-Rule Making website, for further information on how to request access to the separate 2017 MUC project website.

Upcoming Events

All times shown are Eastern Time zone

- OQR: CMS Abstraction and Reporting Tool (CART): Knowing the Basics webinar on March 15, 2017 at 10:00 AM and 2:00 PM
    - Register for the event here
- SNF VBP: Understanding Your Facility's Confidential Feedback Report call on March 15, 2017 at 1:30 - 3:00 PM
    - Register for the event here
- Potential Measures for the IPFQR Program and the Pre-Rulemaking Process webinar on March 21, 2017 at 2:00 PM
    - Register for the event here
- ASC: Staying the Course: Sailing Toward Quality Reporting Success webinar on March 22, 2017 at 2:00 PM - 3:00 PM
    - Register for the event here
- PCHQR Program: Web-Based Data Collection Tool webinar on March 23, 2017 at 2:00 PM
    - Register for the event here
- IMPACT Act: Standardized Patient Assessment Data Activities Call on March 29, 2017 at 1:30 - 3:00 PM
    - Register for the event here

Upcoming Opportunities

Opportunities for Public Comment on quality measures
Currently there are no open public comments. Please check the CMS Quality Measures Public Comment Web Page for current Public Comment announcements and summary reports.

Opportunities to participate in a Technical Expert Panel (TEP)
Currently there are no open TEP Nominations. Please check the CMS Quality Measures Call for TEP Web Page for current TEP membership lists and meeting summaries.

Opportunities to participate in the Call for Measures
- The Annual Call for Measures and Activities for the Merit-based Incentive Payment System (MIPS)

CMS is posting a fact sheet and hosting a webinar to walk stakeholders through the process for the Annual Call for Measures and Activities. This process allows organizations representing eligible clinicians, such as professional associations and medical societies, to identify and submit measures for consideration from the following categories:
   - Measures for the Quality performance category
   - Measures for the Advancing Care Information performance category
   - Activities for the Improvement Activities performance category

All information and supplemental documents must be submitted by June 30, 2017. The final MIPS measures and activities for 2018 will be posted by November 1, 2017.

New to the listserv or miss a month? Find all of our announcements here.

Please send comments and suggestions to MMSSupport@battelle.org.